

6727

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First THOMAS Middle F. Last BARTLETT				4. DATE OF DEATH Month JULY Day 17 Year 1956			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 25, 1875		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Cook - New Century Hotel		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vince Bartlett				14. MOTHER'S MAIDEN NAME Kathleen Gales			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-12-1720		17. INFORMANT Memorial Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis with uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Benign hyper trophy prostate						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-10-56 to 7-17-56 that I last saw the deceased alive on 7-16-56 and that death occurred at 10:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Romney, W. Va. DATE SIGNED 7-17-56							
ACTUAL SIGNATURE Howard L. Tolson M.D.				PHYSICIAN'S NAME (Type) HOWARD L. TOLSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 19, 1956		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Colored Cem.		22d. LOCATION (City, town, or county) (State) Romney W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Beich Shaffer				ADDRESS Romney W. Va.		24a. REC'D BY REGISTRAR July 19, 1956	
				24b. REGISTRAR'S SIGNATURE Winters R. Frantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
JUL 20 1956
BUREAU V. 2

6728

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 514 Dilley Street	
3. NAME OF DECEASED (Type or print) First John Middle L. Last Becker		4. DATE OF DEATH Month July Day 21 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1879
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R. R. worker-Western Md.		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. E.		12. CITIZEN OF WHAT COUNTRY? U. S. E.	
13. FATHER'S NAME Louis Becker		14. MOTHER'S MAIDEN NAME Elizabeth Michaels	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Allegany County Infirmary Records		Address P.O. Box 599	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Pulmonary Hypertension		INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis deformans		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/23/56 , 19____, to 7/21/56 , 19____, that I last saw the deceased alive on 7/21/56 , 19____, and that death occurred at 4:48 P. M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE James E. McLean M.D.	ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md. DATE SIGNED 7/23/56
PHYSICIAN'S NAME (Type) Dr. James E. McLean	

22a. BURIAL, CREMATION, OR REMOVAL (Specify) Buried	22b. DATE THEREOF 7/25/56	22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumberland Md.	24a. REC'D BY REGISTRAR July 24, 1956
		24b. REGISTRAR'S SIGNATURE W. E. Hantz M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 25 1956

BUREAU A. F.

25 JUL 2005

Model 2 $\chi^2(2) = 68.97$, $p < .001$

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that this death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06710

CERTIFICATE OF DEATH

Reg. Dist. No. 9

6782

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frostburg		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nikep		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) Emma Bestjancic				4. DATE OF DEATH (Month) (Day) (Year) 7/24/1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 4/2/1893	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work Own Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lenaconing		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arch Brown				14. MOTHER'S MAIDEN NAME Emma Beeman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Lester Watkinson			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Daughter)		INTERVAL BETWEEN ONSET AND DEATH	
550.0 IMMEDIATE CAUSE (A) Uremia						4 Days	
ANTECEDENT CAUSE(S) DUE TO (B) Acute Congenous Appendicitis						7 Days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Hypertension							
19a. DATE OF OPERATION July 21/1956		19b. MAJOR FINDINGS OF OPERATION Acute Congenous Appendicitis		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 20, 1956 , to July 24, 1956 , that I last saw the deceased alive on July 23, 1956 , and that death occurred at 9:25 A.M. from the causes and on the date stated above.							
SIGNATURE W. Mc Lane MD				ADDRESS (Street, city, town, state) Frostburg MD		DATE SIGNED July 27 1956	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 7/28/1956		NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		LOCATION (City, town, or county) (State) Moscow, MD.	
24. REC'D BY REGISTRAR DATE 7-28-56		REGISTRAR'S SIGNATURE Wm. Nalley N. Roe		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lenaconing, MD.			

CERTIFICATE OF DEATH

BUREAU VI

JUL 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Public Corporate Death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729

CERTIFICATE OF DEATH

Reg. Dist. No.

06711

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Inside City Limits)			c. LENGTH OF STAY IN 1b 10 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willowbrook Road			d. STREET ADDRESS Willowbrook Road		
3. NAME OF DECEASED (Type or print) First Ida Middle Belle Last Bible			4. DATE OF DEATH Month July Day 13 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Morral		
14. MOTHER'S MAIDEN NAME Rebecca Dean			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. none			17. INFORMANT Melvin Bible Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 years DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from July 13, 1956 to July 13, 1956 that I last saw the deceased alive on July 13, 1956 , and that death occurred at 7:40 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. T. Johnson		M.D. Cumberland, Md.		DATE SIGNED 7-16-56	
PHYSICIAN'S NAME (Type) W. T. Johnson		M.D. James T. Johnson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/16/56	22c. NAME OF CEMETERY OR CREMATORY Bible Cemetery	22d. LOCATION (City, town, or county)	(State) Flintstone, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR July 16, 1956	24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED

BUREAU V. 4

JUL 18 1956

RECEIVED

DR. R. J. WMS. 6730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle BITTINGER Last BITTINGER				4. DATE OF DEATH Month JULY Day 14 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 5, 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83		IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME CHARLES WARNICK				14. MOTHER'S MAIDEN NAME MARTHA FAZENBAKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL-MEMORIAL & WARWICK AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Hypertension (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 24 hrs not known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/13/56 , 19 56 , to 7/14/56 , 19 56 , that I last saw the deceased alive on 7/14/56 , 19 56 , and that death occurred at 5:58 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 7/14/56 ACTUAL SIGNATURE B. J. WILLIAMS, M.D. PHYSICIAN'S NAME (Type) B. J. WILLIAMS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-17-56		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	
22d. LOCATION (City, town, or county) Moscow, Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Edw. H. Boone				ADDRESS Westport, Ind.		24a. REC'D BY REGISTRAR July 16, 1956	
24b. REGISTRAR'S SIGNATURE W. R. Hantz, M.D.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

CERTIFICATE OF DEATH

STATE

ALLEGANY

NUMBER

SIXTY

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BUREAU V. 4

JUL 18 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

6731

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>14</u> days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>111 Main St.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Monroe Bower</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1956</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 21-1936</u>
9. AGE (in years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Apprentice, electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric, in lbrs.</u>	
11. BIRTHPLACE (State or foreign country) <u>Morgantown, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harley Bower</u>		14. MOTHER'S MAIDEN NAME <u>Donna Stull</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>235-52-2951</u>	
17. INFORMANT <u>Memorial Hospital record's.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO (b) <u>1st, 2nd, 3rd degree burns of body</u> DUE TO (c) <u>Gas leak, explosion & flash fire.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>late glass plant.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Gas leak, explosion & flash fire at the new glass plant.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> a. m. <u>6-10</u> p. m. <u>1956</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>101 1/2 range Cumberland Allegany Md.</u>		20f. (City or town) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Doming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Doming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 3-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 6, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Morgantown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Morgantown, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred L. Jenkins Funeral Home, Morgantown,</u>		24. REC'D BY REGISTRAR <u>July 6, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>H. V. Doming M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956

RECEIVED

JUL 9 1956

U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 414 Hill St.	
3. NAME OF DECEASED (Type or print) John Joseph Brant		4. DATE OF DEATH July 27 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14-1899
9. AGE (in years last birthday) 56 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Brant		14. MOTHER'S MAIDEN NAME Veletta Pitzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Memorial Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lymphatic leukemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Retroperitoneal hemorrhage (c) Enlarged spleen Petechia of lungs. INTERVAL BETWEEN ONSET AND DEATH 4 yrs 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 27-1956	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1956	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Light, Cumberland, Md.		24. REG'D BY REGISTRAR July 29, 1956	
		24b. REGISTRAR'S SIGNATURE H.V. Deming M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUL 31 1936

RECEIVED
JUL 31 1936

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep		c. LENGTH OF STAY IN 1b Nikep	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In garage at home.		d. STREET ADDRESS Box 181 Barton, Md.	
3. NAME OF DECEASED (Type or print) Bertha		4. DATE OF DEATH Month July Day 27 Year 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19-1892
9. AGE (in years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY (rural) Garrett, Co.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Anna Winebrener	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (son) Forest Broadwater, Nikep, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to strangulation by Hanging DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Hung herself in garage by strips of muslin.	
20c. TIME OF INJURY Month, Day, Year 3.30 p.m. July 27 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home, in garage	20f. (City or town) (County) (State) Nikep, Allegany Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
22b. DATE THEREOF 7-30-56		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill	
23. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		24a. REC'D BY REGISTRAR 7/28/56	
24b. REGISTRAR'S SIGNATURE James M. Boal		24c. REGISTRAR'S SIGNATURE James M. Boal	

NEWMAN FUNERAL HOME, GRANSVILLE, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7 4 1933

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6793
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) REBECCA JANE BRODE		4. DATE OF DEATH Month JULY Day 11 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1895
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wm. H. Barnes	
14. MOTHER'S MAIDEN NAME Ellen J. Loar		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Albert Ritchie, Rt. 1, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of the TRANSVERSE Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from AUG. 1955 to July 11, 1956 , that I last saw the deceased alive on July 9, 1956 , and that death occurred at 4 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Devers M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Frostburg, Md. 7/11/56	
PHYSICIAN'S NAME (Type) John C. Devers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-13-1956	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 7-13-56		24b. REGISTRAR'S SIGNATURE Willie L. H. R. R.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. P.

JUL 19 1956

RECEIVED
JUL 19 1956

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06717

6733

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany	MARYLAND	STATE Maryland	COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland	LENGTH OF STAY (in this place) 2/25/55	CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary		STREET ADDRESS (If rural give location) 315 Maryland Avenue	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Oscar (Middle) Earl (Last) Burkett		(Month) July (Day) 12 (Year) 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 3/30/1894
9. AGE last birthday 62 yrs		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter- Celanese Corp.		10b. KIND OF BUSINESS OR INDUSTRY Ellerslie, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Harvey Burkett		14. MOTHER'S MAIDEN NAME Deborah Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-0246	
17. INFORMANT & ADDRESS Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)		Cerebral Hemorrhage	
ANTECEDENT CAUSE(S) DUE TO		Cerebral Arteriosclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		Chronic Myocarditis	
		Chronic Nephritis	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/25/1955 to 7/12/1956 , that I last saw the deceased alive on 7/12/1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
SIGNATURE Dr. James E. McLean		DATE SIGNED 7/13/56	
ADDRESS (Street, city, town, state) M.D. 49 Greene St., Cumberland, Md.			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		24. REC'D BY REGISTRAR July 15, 1956	
DATE THEREOF 7/15/56		NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
LOCATION (City, town, or county) (State) Cumberland, Maryland		25. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George	
ADDRESS Cumberland, Md.			

V5 A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

RECEIVED
JUL 18 1956

RECEIVED
JUL 18 1956

06718

6734

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland		LENGTH OF STAY (in this place) 11/23/53		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 232 N. Centre Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Mabel		(Middle) L.		(Last) Byrd		(Day) July 10,	
(Year) 19						(Year) 56	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 6/8/1894	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Cover Home	11. BIRTHPLACE (State or foreign country) Upper Track, Pennsylvania (Pendleton County)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Solon K. Lantz				14. MOTHER'S MAIDEN NAME Mary Alice Teter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 220-10-9367		17. INFORMANT & ADDRESS Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH ?			
ANTECEDENT CAUSE(S) DUE TO (B) General arteriosclerosis				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Secondary anemia -				?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arthritis Deformans				?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/23 / 1953 to 7/10 / 1956 , that I last saw the deceased alive on 7/10 / 1956 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
Dr. James E. McLean M.D.				ADDRESS (Street, city, town, state) 49 Greene St., Cumberland, Md. DATE SIGNED 7/10/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF July 13, 1956		NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		LOCATION (City, town, or county) (State) Ranklin, West Virginia	
24. REC'D BY REGISTRAR July 12, 1956		REGISTRAR'S SIGNATURE Walter E. Frank, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John J. Mafor,		ADDRESS Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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У А ПУТИНИ

У А ПУТИНИ

6735

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 HRS 45 MINS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
		d. STREET ADDRESS 613 1/2 LOUISIANA AVENUE	
3. NAME OF DECEASED (Type or print) First BERTHA Middle L. Last CARNEY		4. DATE OF DEATH Month 7 Day 5 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 17 1886
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME L. SAMPLE JOHNSON		14. MOTHER'S MAIDEN NAME MARY SWEARENGIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT MEMORIAL HOSPITAL		Address MEMORIAL AVENUE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) disease (c) disease			INTERVAL BETWEEN ONSET AND DEATH 10 Hours.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 19 50 to 7-5-19 56 that I last saw the deceased alive on 7-5-19 56 and that death occurred at 11:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. F. Williams		ADDRESS (Street, city or town, state) Cumberland Md	
PHYSICIAN'S NAME (Type) DR. W.F.WMS.		DATE SIGNED 7-6-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 7 1956	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Williams		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR July 6, 1956
		24b. REGISTRAR'S SIGNATURE W.R. Fantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 9 1956
BUREAU V. A.

6736 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland		LENGTH OF STAY (In this place) 12/7/53		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 438 Goethe Street			
3. NAME OF DECEASED (First) (Middle) (Last) Mary C. Claar				4. DATE OF DEATH (Month) (Day) (Year) July 31, 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 8/15/1866	9. AGE last birthday 89 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Samuel Sellers				14. MOTHER'S MAIDEN NAME Rebecca Mower			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS P. O. Box 599 Allegany County Infirmary Records			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
/ IMMEDIATE CAUSE (A)				Pulmonary Hypostasis			
ANTECEDENT CAUSE(S) DUE TO				Chronic Myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)				General Arteriosclerosis			
(C)				Chronic Nephritis			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/7/53, 19 to 7/31/56, 19, that I last saw the deceased alive on 7/31/56, 19, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
SIGNATURE <i>James E. McLean</i>				DATE SIGNED 8/1/56			
Dr. James E. McLean				M.D. 49 Greene St., Cumberland, Md.			
23. BURIAL, CREMATON, REMOVAL (Specify) Burial		DATE THEREOF 3/6/56		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. REC'D BY REGISTRAR Aug 2, 1956		REGISTRAR'S SIGNATURE <i>Walter E. Frank, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE John J. Harter, Cumberland, Maryland			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M*

88 1

CERTIFICATE OF DEATH

06321

Reg. Dist. No.

6783

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. STREET ADDRESS <u>78 Mt. Pleasant St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>78 Mt. Pleasant Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie Connelley</u>	4. DATE OF DEATH <u>7 8th 19 56</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 - 21 - 1870</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hoffman, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Metzner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ellen Moody</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James Henry Connelley</u>		Address <u>114 Mt. Pleasant St Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myoplasmic of Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Quarantined Anterior Sclerosis, Chronic Myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Two months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 - 27 - 19 56</u> to <u>7 - 8 - 56</u> , that I last saw the deceased alive on <u>7 - 5 - 19 56</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>J. T. Johnson</u> M.D. <u>Chamberland Md</u> <u>7-10-56</u> PHYSICIAN'S NAME (Type) <u>James T. Johnson Jr. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-11-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Montross</u>		24a. REC'D BY REGISTRAR <u>DATE 7-11-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Willie Nancy N. Ras</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNNEN A. S.

JUL 16 1907

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Ch. of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06722

Reg. Dist. No.

4

6737

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>			d. STREET ADDRESS <u>946 Bay St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thornton</u> <u>Warfield</u> <u>Crabtree</u>			4. DATE OF DEATH Month Day Year <u>July</u> <u>19</u> <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24-1898</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>58</u> <u>0</u> <u>0</u> <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R.Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Old Town, Md.</u>	
13. FATHER'S NAME <u>Michael Crabtree</u>			14. MOTHER'S MAIDEN NAME <u>Mdina J. ...</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-05-9630</u>		17. INFORMANT Address <u>Memorial Hospital records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism (passive)</u> about <u>6</u> hrs. DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>post-operative cystolithectomy</u> <u>10 days</u> (a), stating the underlying cause lost. DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H. V. Doring M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Doring M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 19-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Bedford county, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		ADDRESS <u>Hafer</u>		24. REC'D BY REGISTRAR <u>July 21, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>

RECEIVED

JUL 24 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06723

Reg. Dist. No. 4

6738

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First SARAH Middle DANZENBAKER Last DANZENBAKER				4. DATE OF DEATH Month JULY Day 21 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 29, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME DOUGLAS SOMMERVILLE				14. MOTHER'S MAIDEN NAME MARGARET WALKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Terminal Cardiac Failure +45X DUE TO 2. Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 month 2 years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5 July, 1956 , to 21 July, 1956 , that I last saw the deceased alive on 21 July, 1956 , and that death occurred at 7:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) Cumberland, Md.		DATE SIGNED 23 July 56	
PHYSICIAN'S NAME (Type) W A VAN ORMER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery		22d. LOCATION (City, town, or county) (State) Petersburg, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Schaeffer Funeral Home, Petersburg, West Virginia				24a. REC'D BY REGISTRAR DATE July 23, 1956		24b. REGISTRAR'S SIGNATURE W. Frank M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JUL 24 1956

RECEIVED

1. Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06724

6739 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>	<u>4yr.2mo.21da.</u>	TOWN <u>Westernport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat, Furnace St.</u>		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED (Type or Print) <u>Nettie Anna Dawson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 24 1956</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Aug. 10, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Clarkburg, West Va.</u>	
12. FATHER'S NAME <u>James O. Ross</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. MOTHER'S MAIDEN NAME <u>Margaret Guy</u>			14. INFORMANT & ADDRESS <u>Mrs. Hazel Fleagle Corriganville Md</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)		<u>Chronic Myocarditis.</u>		<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO		<u>Coronary Arteriosclerosis</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO		<u>?</u>	
		<u>Chronic Nephritis</u>			
		<u>Smile psychosis.</u>		<u>4 yrs. +</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>May 3, 1952</u> , to <u>July 24, 1956</u> , that I last saw the deceased alive on <u>July 23, 1956</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>James B. DeLeon</u>		M.D.		ADDRESS (Street, city, town, state) <u>49 Greene St.</u>	
DATE SIGNED <u>7-24-56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)		
<u>Burial</u>	<u>7/27/56</u>	<u>Philos Cem</u>	<u>Westernport Md</u>		
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE			
<u>July 26, 1956</u>	<u>Walter R. Frantz, M.D.</u>	<u>E. J. Boral - Westernport, Md</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1974 NOVEMBER

1956

1974

06725

6794 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>				TOWN <u>Cumberland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 6, Narrows Park</u>				STREET ADDRESS (If rural give location) <u>Rt. 6, Narrows Park</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MAUDE</u> (Middle) <u>ESTELLA</u> (Last) <u>DSIELTER</u>				(Month) (Day) (Year) <u>July 16 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 26, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Coartown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Holland Bane</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Loar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Rt. 6 Marshall Deremer, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 19, 19 53</u> , to <u>July 16, 19 56</u> , that I last saw the deceased alive on <u>14th July, 19 56</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William R. James</u> M.D.				ADDRESS (Street, city, town, state) <u>441 N. Centre St. Cumberland, Md.</u>		DATE SIGNED <u>7-17-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>7/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>July 18 1956</u>		REGISTRAR'S SIGNATURE <u>Walter K. Francis, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Rafer, Cumberland, Maryland</u>			

INSTRUCTIONS

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The third copy of the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06726

CERTIFICATE OF DEATH

Reg. Dist. No. 9

6784

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg, R.F.D. # 1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Daniel</u> (First) <u>De Vault</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>7/23.1956</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 9th. 1938</u>	9. AGE last birthday <u>18</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>National, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles De Vault</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mac Beeman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Charles De Vault, (FATHER)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Frostburg, MD.</u>		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)		<u>Congestive heart failure</u>				<u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B)		<u>Aplastic anemia</u>				<u>5 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		<u>Rheumatic fever</u>				<u>4 mos.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 28, 1956</u> , to <u>July 23, 1956</u> , that I last saw the deceased alive on <u>July 23, 1956</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leslie R. Miller Jr.</u>		M.D.		ADDRESS (Street, city, town, state) <u>Lenacoring Md</u>		DATE SIGNED <u>July 25, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/26/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>7-26-56</u>		REGISTRAR'S SIGNATURE <u>Mr. Nancy A. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>George Eichhorn, Lenacoring, MD.</u>			

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מחלקת א' י"א

6740

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital, Memorial Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mrs. Middle Laura Last De Witt				4. DATE OF DEATH Month July Day 29 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 28, 1867	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisa Merrill				14. MOTHER'S MAIDEN NAME Barbara Broadwater			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Memorial Hospital, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 422.1 DUE TO Chr Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Semility DUE TO (c) Semility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 days P.O. - 21 July 56 Intestinal Obst. Hydrops Gallbladder							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 July 1956 , to 29 July 1956 , that I last saw the deceased alive on 29 July 1956 , and that death occurred at 6.10pm , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 123 Bedford St DATE SIGNED 30 July 56							
ACTUAL SIGNATURE Fuller B. Whitworth M.D.				PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home, Westernport, Maryland.				24a. REC'D BY REGISTRAR July 31, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1956 1 5

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6741

CERTIFICATE OF DEATH

06728

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/8/52	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			d. STREET ADDRESS 523 Louisiana Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle G. Last Douglas			4. DATE OF DEATH Month July Day 23 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/1867		9. AGE (In years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Mining		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Douglas			14. MOTHER'S MAIDEN NAME Mary Ghrame		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 76		17. INFORMANT Address P.O. Box 599 Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertension DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Small Arteriosclerosis (c) Chronic Prostatitis					INTERVAL BETWEEN ONSET AND DEATH 24 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Prostatitis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19	
20f. (City or town) 19		20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from 11/8/52 , 19____ to 7/23/56 , 19____ that I last saw the deceased alive on 7/23/56 , 19____, and that death occurred at 11:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md. DATE SIGNED 7/24/56					
ACTUAL SIGNATURE James E. McLean					
PHYSICIAN'S NAME (Type) Dr. James E. McLean					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/56		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
22d. LOCATION (City, town, or county) Lonaconing		22e. (State) Md.		22f. (Country) U. S. A.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR July 26, 1956	
24b. REGISTRAR'S SIGNATURE Winter L. Hunt, M.D.		24c. (City, town, or county) Lonaconing			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 27 1956

JUL 27 1956

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06729

6795

CERTIFICATE OF-DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lonaconing</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>High Street</u>				STREET ADDRESS (If rural give location) <u>High Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna</u> (First) <u>Duckworth</u> (Middle) (Last)				4. DATE OF DEATH <u>July 25</u> 19 <u>56</u> (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 27, 1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Larue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Calvin Duckworth, (SON)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Lonaconing, MD.</u>		INTERVAL BETWEEN ONSET, AND DEATH <u>1 hour</u>	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 25, 1956</u> , to <u>July 25, 1956</u> , that I last saw the deceased alive on <u>July 25, 1956</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leslie R. Miles Jr.</u>				ADDRESS (Street, city, town, state) <u>Lonaconing Md.</u>		DATE SIGNED <u>July 25 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 27, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lonaconing, Md.</u>	
24. REC'D BY REGISTRAR <u>7/28/56</u>		REGISTRAR'S SIGNATURE <u>Juanita M. Boal</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>		ADDRESS <u>Lonaconing, Md.</u>	

INSTRUCTIONS

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be examined within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY
WASHINGTON, D. C.

6742

CERTIFICATE OF DEATH

06730

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
c. LENGTH OF STAY IN 1b <u>89 Years</u>		d. STREET ADDRESS <u>48. Browning St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>48. Browning St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joanna</u> Middle <u>—</u> Last <u>Dunlap</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16 1866</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Cheston Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Louise Jackson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Thomas Ricker, Cumberland, Md.</u> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>400.1</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mths</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan 1, 1951</u> , to <u>July 22, 1957</u> , that I last saw the deceased alive on <u>July 21, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Clayton L. Burnett</u> M.D. <u>236 The Highlands</u>		DATE SIGNED <u>7/23/58</u>
PHYSICIAN'S NAME (Type) <u>—</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 25 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyndman Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 25 1956
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Id</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>4 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>			d. STREET ADDRESS <u>826 Mt. Royal Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Little</u> Last <u>Thbert</u>			4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 56</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20-1950</u>		9. AGE (In years last birthday) <u>6</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Little Thbert Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Elta May Schultz</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Memorial Hospital records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, head injuries with a depressed skull fracture, intracranial hemorrhage, cerebral</u> DUE TO <u>fracture, intracranial hemorrhage, cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>injury extensive. Fell from an apple tree.</u> DUE TO <u>injury extensive. Fell from an apple tree.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Climbed apple tree, fell about 12 ft. striking on head.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Climbed apple tree, fell about 12 ft. striking on head.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>12:15</u> <u>7-22</u> <u>19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back yard, home</u>	
				20f. (City or town) (County) (State) <u>Cumberland Allegany Id.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>July 23-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 24, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>			24a. REC'D BY REGISTRAR <u>July 24, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the certificate. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU 7. 2

JUL 25 1956

10

CERTIFICATE OF DEATH

6744

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Alle any</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Alle any</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>5 wks</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>127 South Mechanic Street</u>				STREET ADDRESS (If rural give location) <u>127 South Mechanic Street</u>			
3. NAME OF DECEASED (Type or Print) <u>SILAS</u> (First) <u>ELBIN</u> (Middle) (Last)				4. DATE OF DEATH <u>July 10</u> (Month) (Day) (Year) <u>19 56</u>			
5. SEX <u>ale</u>	6. COLOR OR RACE <u>ite</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Apr. 20, 1970</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor & Odd</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Elbinsville, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John George Elbin</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Lashley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>210-26-5236</u>		17. INFORMANT & ADDRESS <u>127 S. Mechanic St. Ada Lashley, Cumberland, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma liver with metastases</u>						<u>Unknown</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u>, 19 <u>56</u>, to <u>July</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>July 8</u>, 19 <u>56</u>, and that death occurred at <u>3:04 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. 133 Virginia Ave, Cumberland, Md</u>		DATE SIGNED <u>JULY 10 1956</u>	
23. MANNER, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 12, '56</u>		NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cem.</u>		LOCATION (City, town, or county) (State) <u>Alle any, Md.</u>	
24. REC'D BY REGISTRAR <u>July 12, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Lafer,</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

1. TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED
JAN 10 1900
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

Within Corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06733

CERTIFICATE OF DEATH

6745

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland COUNTY Allegany		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland		STREET ADDRESS (If rural give location) 23 New Hampshire Avenue	
CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland		LENGTH OF STAY (in this place) 1/18/56		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland		STREET ADDRESS (If rural give location) 23 New Hampshire Avenue	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 23 New Hampshire Avenue			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) (Evans) Sarah B. Evans				4. DATE OF DEATH (Month) (Day) (Year) July 29, 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 1-7-75	9. AGE (at birthday) 81 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Charles Brode				14. MOTHER'S MAIDEN NAME Catherine Gerlock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS P. O. Box 599 Allegany County Infirmary Records			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Chronic myocarditis				>	
ANTECEDENT CAUSE(S) DUE TO (B) General arteriosclerosis				>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Acute renal necrosis				>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic nephritis				>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **7/18/56**, to **7/29/56**, that I last saw the deceased alive on **1/29/56**, and that death occurred at **11:00 P.M.** from the causes and on the date stated above.

SIGNATURE Dr. James E. McLean		ADDRESS (Street, city, town, state) 49 Greene St., Cumberland, Md.		DATE SIGNED 7/30/56	
23. BURIAL, CREMATION, REMOVAL (Specify) burial		DATE THEREOF 1/31/56		NAME OF CEMETERY OR CREMATORY Union Hill Cemetery	
24. REC'D BY REGISTRAR July 31, 1956		REGISTRAR'S SIGNATURE Walter R. Bantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John J. Baker, Cumberland, Maryland	

INSTRUCTIONS

TO APPOINTING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

OF THE UNITED STATES

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U.S. DEPARTMENT OF THE INTERIOR

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06734

Reg. Dist. No.

6796

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>W.Va.</u> b. COUNTY <u>Hampshire</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Old Town</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route " 51</u>		d. STREET ADDRESS <u>Augusta</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Asa</u> <u>McBride</u> <u>Everett</u>		4. DATE OF DEATH Month Day Year <u>July</u> <u>6</u> <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27-1900</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired, machinist helper-D.O.P. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shan's, W.Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob J. Everett</u>		14. MOTHER'S MAIDEN NAME <u>Aranda C. Swisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>721-16-9550</u>	
17. INFORMANT Address <u>Mrs. Mary Davis, Old Town, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Shock- PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage due to a fractured skull.</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>skull, comminuted fracture of left parietal bone.</u> DUE TO (c) <u>fractured also nose.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Walking, route 51, hit & run, near Old Town, W. Va.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Walking, route 51, hit & run, near Old Town, W. Va.</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-25-7-6</u> <u>19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at 51</u>		20f. (City or town) (County) (State) <u>Old Town Allegany W. Va.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>July 6-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-8-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Points, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>July 8, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mrs. Taylor</u>	

TO REPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 7 years. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUL 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06735

6785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Route 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First NORMAN Middle GARLITZ Last GARLITZ		4. DATE OF DEATH Month July Day 18 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1883
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Garlitz		14. MOTHER'S MAIDEN NAME Nancy Durst	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 189-22-6902	
17. INFORMANT Mrs. Norman Garlitz, Rt. 2, Frostburg, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 9, 1956 , to July 18, 1956 , that I last saw the deceased alive on July 18, 1956 , and that death occurred at 4:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md. DATE SIGNED 7-19-56			
ACTUAL SIGNATURE Hilda Jane Walters, M. D.		PHYSICIAN'S NAME (Type) Hilda Jane Walters, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-21-1956	22c. NAME OF CEMETERY OR CREMATORY Blocher Cemetery	22d. LOCATION (City, town, or county) (State) Garrett County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 7-20-56	24b. REGISTRAR'S SIGNATURE Mr B. O. Price

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

JUL 21 1901

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06736

Within corporate limits

DR. SIMONS

6746

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 15 4 HRS. 25 MIN. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE d. STREET ADDRESS BOX 128 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle E Last GEHR		4. DATE OF DEATH Month JULY Day 19 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 2, 1889
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Int. Agent		10b. KIND OF BUSINESS OR INDUSTRY W. V. Railroad	
11. BIRTHPLACE (State or foreign country) MARYLAND, Indian Spring		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GEHR		14. MOTHER'S MAIDEN NAME MARY COOK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1918-1919		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVES.	
17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 hrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1/56 , 19 56 , to 7/2/56 , 19 56 , that I last saw the deceased alive on 7/1/56 , 19 56 , and that death occurred at 11:35 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George M. Simons M.D.		ADDRESS (Street, city or town, state) Cumberland Md 128 Union St.	
DATE SIGNED 7/2/56			
PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/56	
22c. NAME OF CEMETERY OR CREMATORY West Haven Cemetery		22d. LOCATION (City, town, or county) (State) LaVale, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR July 22, 1956 24b. REGISTRAR'S SIGNATURE W. K. Frank, R. D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

JUL 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06737

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>back yard at home. 108 N. Mallwood St.</u>		d. STREET ADDRESS <u>108 N. Mallwood St.</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick J. Grabenstein</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1-1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retire - merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Market</u>	
11. BIRTHPLACE (State or foreign country) <u>Mineral Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Justus Grabenstein</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Mundy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. J. J. Overstein, Cumberland, Id.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary sclerosis</u> <u>420.1</u> DUE TO (b) <u>Chronic myocarditis with ascites</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 7-1956</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-10-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>S.S. Peter & Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>July 9/1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Grant, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Department of Health. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

W. A. JONES

1956

1956

Within corporate limits.

6748

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 Grand Ave.		d. STREET ADDRESS 70 Grand Ave.	
3. NAME OF DECEASED (Type or print) First Richard Middle Henry Last Guthridge		4. DATE OF DEATH Month July Day 10 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1902
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Brownsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-08-3740	
17. INFORMANT Mrs. Richard H. Guthridge, Cumberland		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - DUE TO Art Sch. Corp. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from 4/15/52 , 19____, to 7/16/56 , 19____, that I last saw the deceased alive on 7/14/56 , 19____, and that death occurred at 3 P.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Richard J. Williams		ADDRESS (Street, city or town, state) 122 S. Centre Street M.D.	
PHYSICIAN'S NAME (Type) Richard J. Williams, M.D.		DATE SIGNED 7/17/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 1956	
22c. NAME OF CEMETERY OR CREMATORY Hilcrest		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James P. Carrelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR July 18, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. ST.

1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial or cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07773

Reg. Dist. No.

9

6786

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Pa. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Myersdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hafer Funeral Home		d. STREET ADDRESS 408 Lincoln Ave	
3. NAME OF DECEASED (Type or print) Charles Allen Hahn		4. DATE OF DEATH Month July Day 27 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2-1928
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY W.Md.R.Ry.	11. BIRTHPLACE (State or foreign country) Garrett, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Allen R. Hahn	
14. MOTHER'S MAIDEN NAME Viola Fuller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.2	
16. SOCIAL SECURITY NO. 175-20-486		17. INFORMANT (father) Allen R. Hahn, Myersdale, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage due to a crushed DUE TO (b) with severe brain injury, right side. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Auto accident.		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) turned over.			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Predume excessive speed, auto turned around twice &	
20c. TIME OF INJURY Month, Day, Year 12.05-7-27 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway, Rt. 40		20f. (City or town) (County) (State) Frostburg, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED July 27-1956	
NAME (Type) H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF July 30-1956	22c. NAME OF CEMETERY OR CREMATORY Union Cemetery	22d. LOCATION (City, town, or county) (State) Myersdale Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Price Funeral Home, Myersdale, Pa.		24. REC'D BY REGISTRAR 8-6-56	
24b. REGISTRAR'S SIGNATURE Wm. Stanley M. Roe			

BURTON A. B.

1952

RECEIVED

6797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If inst't on: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian			
c. LENGTH OF STAY in 1b Lifetime				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anthony Middle Harvey Last Harvey				4. DATE OF DEATH Month July Day 25 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Judge		10b. KIND OF BUSINESS OR INDUSTRY People's Court		11. BIRTHPLACE (State or foreign country) Midlothian		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Harvey				14. MOTHER'S MAIDEN NAME Mary Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT 40 Grant Street Mrs. Elmer Jones Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial insufficiency DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Several years 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1954 19 July 25 , 19 56 , that I last saw the deceased alive on June 23 , 19 56 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. O. Mc Lane MD				ADDRESS (Street, city or town, state) Frostburg Md.			
PHYSICIAN'S NAME (Type) W. O. Mc Lane MD				DATE SIGNED July 25 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-56		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Montmarant				ADDRESS HAFER FUNERAL HOME E. A. N. FROSTBURG, MD.		24a. REC'D BY REGISTRAR DATE 7-30-56	
				24b. REGISTRAR'S SIGNATURE Dee Nancy H. Re			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

3 1 1956

100-100000

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HARDY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ETHEL Middle J. Last HEDRICK		4. DATE OF DEATH Month JULY Day 25 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 20, 1899 59 AGE (In years last birthday) 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Laborer in Poultry Dressing Plant		11. BIRTHPLACE (State or foreign country) Hardy County, W. Va.	
13. FATHER'S NAME CLARK HEAVNER		14. MOTHER'S MAIDEN NAME Martha L. Heavner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 235-30-0123	
17. INFORMANT Mrs. Nellie Ebert, Moorefield, West Virginia.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 July 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 July, 1956 , to 25 July, 1956 , that I last saw the deceased alive on 25 July, 1956 , and that death occurred at 6:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. A. Van Ormer		ADDRESS (Street, city or town, state) Cumberland, Md	
PHYSICIAN'S NAME (Type) W. A. VAN ORMER		DATE SIGNED 25 July 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-56	
22c. NAME OF CEMETERY OR CREMATORY Christ Cemetery		22d. LOCATION (City, town, or county) (State) Moorefield, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas's Funeral Home		ADDRESS Moorefield	
24a. REC'D BY REGISTRAR July 26, 1956		24b. REGISTRAR'S SIGNATURE W. D. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 27 1956

MISSOURI

6750

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 7, 11	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IVY Middle S Last HIGGS.		4. DATE OF DEATH Month JULY Day 17 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1887
9. AGE (In years last birthday) 68 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS MEDLIN		14. MOTHER'S MAIDEN NAME LENA LAWRENCE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Franklin Sherwood, Rawlings, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 400 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-18-1956 to 7-17-1956 , that I last saw the deceased alive on 7-17-1956 , and that death occurred at 8:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams		ADDRESS (Street, city or town, state) Cumberland Md	
DATE SIGNED 7-18-56			
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July, 20, 1956	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Forest Park, Ill.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR July 20, 1956		24b. REGISTRAR'S SIGNATURE Walter K. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6751

CERTIFICATE OF DEATH

06742

Reg. Dist. No.

With In corporate limits

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS 718 Yale St.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 718 Yale St.,		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROY Middle OLIVER Last HINKLE		4. DATE OF DEATH Month July Day 2, Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1895
9 AGE (In years last birthday) 61 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James O. S. Hinkle		14. MOTHER'S MAIDEN NAME Susan Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO 217-10-7219	
17. INFORMANT Mrs. Mamie Hinkle		Address 718 Yale St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4:00.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) Not done		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15/56 19, to 7/2/56 19, that I last saw the deceased alive on 6/15/56 19, and that death occurred at 12:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED Richard J. Williams M. D.			
ACTUAL SIGNATURE Richard J. Williams M. D.		PHYSICIAN'S NAME (Type) Richard J. Williams M. D. Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/4/56	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23 FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE 7/3, 1956		24b. REGISTRAR'S SIGNATURE W. F. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT A. BROWN

1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06743

Reg. Dist. No.

9

6787

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Rural) Rt. #3 Myersdale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O. Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wayne Joseph Hostetler		4. DATE OF DEATH Month July Day 29 Year 1956					
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20-1953		9. AGE (in years last birthday) 3 yrs.	IF UNDER 1 YEAR Months 3 Days 19 Hours 56	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Myersdale, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME C. Carl Hostetler				14. MOTHER'S MAIDEN NAME Verna Catherine Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address R.F.D. #3 (father) C. Carl Hostetler, Myersdale, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Strangulation (accidental) DUE TO (c) sudden						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, location, and manner) cord, which hung on a nail. Unknown manner, found with head through loop of baling					
20c. TIME OF INJURY Month, Day, Year Hour 3.15 p.m. 7-29 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural, Rt. #3 (County) Somerset Pa.		20f. INJURY OCCURRED In shed, at home	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 29-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-56		22c. NAME OF CEMETERY OR CREMATORY Finzel Cemetery		22d. LOCATION (City, town, or county) (State) Finzel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Buried H. Montsant				24a. REC'D BY REGISTRAR 23 E. Main, Frostburg		24b. REGISTRAR'S SIGNATURE DATE 8-1-56	

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 14 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

about

RECEIVED
JUN 5 1956
BUREAU V. A.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

6752

1. PLACE OF DEATH

COUNTY Allegany
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN Cumberland,MARYLAND
LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Cresaptown,STREET
ADDRESS (If rural give location)
Cresap Park3. NAME OF
DECEASED
(Type or Print)(First) (Middle) (Last)
DELLA FLORENCE KILE4. DATE
OF
DEATH (Month) (Day) (Year)
July 23, 19 565. SEX
Female6. COLOR OR
RACE
White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Widowed8. DATE OF BIRTH
January 8, 18699. AGE last birthday
87 yrs.IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) Housewife10b. KIND OF BUSINESS
OR INDUSTRY
Own home

11. BIRTHPLACE (State or foreign country)

Pendleton Co., W. Va.12. CITIZEN OF WHAT
COUNTRY?U. S.

13. FATHER'S NAME

Morgan D. Lambert

14. MOTHER'S MAIDEN NAME

Martha Ann Simmons15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)
No,16. SOCIAL SECURITY NO.
None

17. INFORMANT & ADDRESS

Mr. Jesse H. Simmons Ridgetown, W. Va.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

22. I IMMEDIATE CAUSE (A)
ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST, DUE TO
(B) (C)Cerebral vascular accidentCerebral sclerosisII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH
3 weeks5 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-30-1956, to 7-23-1956, that I last saw the deceased
alive on 7-23-1956, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

SIGNATURE

Lynn W. Bacon

ADDRESS (Street, city, town, state)

DATE SIGNED

M.D. 62 Greene St., Cumberland, Md. 7/23/5623. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial7/25/56Cedar Hill CemeteryFranklin, W. Va.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

July 23, 1956Winter R. Frank, M.D.Charles L. George Cumberland, Maryland

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. 1

JUL 24 1956

RECEIVED

CERTIFICATE OF DEATH

6753

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY <u>Mt. Savage</u>		TOWN <u>Mt. Savage</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Cumberland</u>		<u>6</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat Furnace St</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>Phillip</u> (Last) <u>Kirby</u>				(Month) <u>7</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>12-31-1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>brick yard</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Phillip Kirby</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Metz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>213-10-9122</u>		17. INFORMANT & ADDRESS <u>Roy Kirby, Mt. Savage, Md.</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
542 X IMMEDIATE CAUSE (A) <u>Chronic Myocardial Deterioration</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arteriosclerosis</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Nephritis</u>				<u>?</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>				<u>2 mos</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 2, 1956</u> to <u>July 25, 1956</u> that I last saw the deceased alive on <u>July 24, 1956</u> and that death occurred at <u>Mt. Savage</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. Cheave</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Greiner St. Mt. Savage, Md.</u>		DATE SIGNED <u>7-25-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. R. Durst</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	
DATE <u>7/27/56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The **1** requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate **1** should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U.S. DEPARTMENT OF AGRICULTURE

10

Jan. 11. 1900. In Pool

Jan. 11. 1900. In Pool

VS. A15ME(S)
SM 9/55

RECEIVED
JUL 25 1956
NEW YORK

Within corporate limits

6754

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 133 SOUTH LIBERTY ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last KORNOFF		4. DATE OF DEATH Month JULY Day 8 Year 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1868
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CASPERLINE, CO. RAD CASPERLINE		14. MOTHER'S MAIDEN NAME CAROLINE SHILLING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address MEMORIAL AVE., CUMBERLAND,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive Heart failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis and severe anemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-20 , 19 56 to 7-8 , 19 56 , that I last saw the deceased alive on 7-8 , 19 56 , and that death occurred at 8:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William P. James M.D.		ADDRESS (Street, city or town, state) 441 W. Centre St. Cumberland, Md.	
DATE SIGNED 7-10-56			
PHYSICIAN'S NAME (Type) William P. James, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10, 1956	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR July 10, 1956		24b. REGISTRAR'S SIGNATURE W. K. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1955

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

6755

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/16/55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 1300 Bedford Street	
3. NAME OF DECEASED (Type or print) First Katherine Middle E. Last Larkin		4. DATE OF DEATH Month July Day 24 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1869
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Warfarsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas E. Shives		14. MOTHER'S MAIDEN NAME Mary Richards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Allegany County Infirmary Records		Address P.O. Box 599	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 72 hrs ? ?	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Small Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/16/55 , 19____, to 7/24/56 , 19____, that I last saw the deceased alive on 7/24/56 , 19____, and that death occurred at 2:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 7/24/56			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-56	
22c. NAME OF CEMETERY OR CREMATORY Carr Hill Cemetery		22d. LOCATION (City, town, or county) (State) P. M. P. W., V. V.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR July 26, 1956	
24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

1956

11/14/56

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06749

6756

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>39 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 E. Oldtown Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lathrum</u> Last <u>Lathrum</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1916</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Loudoun County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. R. Kirk Lathrum, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>31X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>OLD AGE</u> DUE TO (c) <u>ARTERIO SCLEROTIC VASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>56</u> , to <u>JULY</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>56</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Overton Himmelwright, M.D.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>G. OVERTON HIMMELWRIGHT, M.D.</u> <u>7/17/56</u>			
PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright, M.D.</u>				133 VIRGINIA AVENUE PH. <u>PA-2-6242</u> <u>CUMBERLAND, MD.</u> (State)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 18, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Willowbrook</u>		22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. McDaniel, Cumberland, Md.</u>				24. REC'D BY REGISTRAR <u>July 18, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Frost, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 19 1956
BUREAU V. S.

CERTIFICATE OF DEATH

6757

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany				STATE Maryland COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Cumberland		7/14/56		New Cumberland, Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS Rt. 3, Hazen Road			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Florence B. Leasure				July 26, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	6/14/1885	71 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Berryville, Virginia		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Eugene Russell				Nellie Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		P. O. Box 599 Allegany County Infirmary Records			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
I. IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
Pulmonary Hypostasis				24 hrs			
II. ANTECEDENT CAUSE(S) DUE TO							
Chronic Dryocarditis				>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
General arteriosclerosis				?			
III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
Chronic nephritis				>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/14/56 , 19 56 , to 7/26/56 , 19 56 , that I last saw the deceased alive on 7/26/56 , 19 56 , and that death occurred at 4:45 PM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
Dr. J. E. McLean		49 Greene St., Cumberland, Md.		7/27/56			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 29 1956		Zion Memorial Burial Park		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. PUBLIC HEALTH DIRECTOR'S SIGNATURE		ADDRESS	
July 28, 1956		W. R. Frantz, M.D.		[Signature]		Cumberland, Md.	

INSTRUCTIONS

THE BOTTOM COPY MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE TOP COPY SHOULD BE DETACHED FOR USE AS A BURIAL TRANSIT PERMIT.

VS A15C 1-55 10M

BUREAU W. S.

ED

Outside of City Limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

6799

CERTIFICATE OF DEATH

06751

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 6 Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 6 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Locust Grove				e. STREET ADDRESS Locust Grove			
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last LEASURE				4. DATE OF DEATH Month July Day 14 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1882	9. AGE (in years last birthday) 74 yrs	IF UNDER 1 YEAR Months 14 Days 19 Hours 56	IF UNDER 24 HRS. Months 14 Days 19 Hours 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Galipolis, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Otis Snyder				14. MOTHER'S MAIDEN NAME Lucille (Last name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. Walter S. Leasure Rt. # 6 Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 6-11-56 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukemia Mellitosa DUE TO (c) Coronary						INTERVAL BETWEEN ONSET AND DEATH 6-11-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 5, 1956 to July 14, 1956 , that I last saw the deceased alive on July 14, 1956 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Virginia Ave., DATE SIGNED Dr. Clay E. Durrett							
ACTUAL SIGNATURE Clay E. Durrett M.D.				23b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			
PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/56		22c. NAME OF CEMETERY OR CREMATORY Fellowship Cem.		22d. LOCATION (City, town, or county) (State) Centreville, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				24. REC'D BY REGISTRAR July 17, 1956			
Cumberland, Md.							

BUREAU A. F.

1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06752

6758
Within corporate limits.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 810 EDGEWOOD DRIVE				d. STREET ADDRESS 810 EDGEWOOD DRIVE			
3. NAME OF DECEASED (Type or print) First WALTER Middle GEORGE Last LEIBRANT				4. DATE OF DEATH Month JULY Day 30 Year 19 56			
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19, 1883	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAFE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY OWN CAFE		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE LEIBRANT				14. MOTHER'S MAIDEN NAME ELIZABETH RUED			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 05 4957		17. INFORMANT Address Mrs. Nina E. Leibrant, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 30, 1956 , to July 30 1956 that I last saw the deceased alive on July 30, 1956 , and that death occurred at 1130 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. B. Matthews		M.D. 49 Green St		ADDRESS (Street, city or town, state)		DATE SIGNED 7/30/56	
PHYSICIAN'S NAME (Type) L. B. Matthews MD		Cumberland Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 1, 1956	22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE 8/1/56		24b. REGISTRAR'S SIGNATURE W. R. Frantz, MD.	

BUREAU V. P.

AUG 1 1900

RECEIVED

6800

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland, rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D.#5, Cumberland, rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Winchester Road, R. F. D. #5</u>		d. STREET ADDRESS <u>Winchester Road, R.F.D. #5</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>E.</u> Last <u>LEWIS</u>		4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1288</u> <u>2 - 10 -</u>
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>215-34-4400</u>	
17. INFORMANT <u>R.D.#5, Address</u> <u>Mrs. Sarah Lewis, Cumberland, Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerosis heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-2-</u> , 19 <u>56</u> , to <u>7-4-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-1-</u> , 19 <u>56</u> , and that death occurred at <u>5 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5700 Green St., Cumberland, Md.</u> DATE SIGNED <u>7-5-56</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS</u> <u>CUMBERLAND</u> <u>Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7 - 7 - 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>	22d. LOCATION (City, town, or county) (State) <u>Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Montecout</u> ADDRESS <u>23 E. MAIN, FROSTBURG, MD.</u>		24a. REC'D BY REGISTRAR <u>W. R. Brantley, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

181 AUG 1941

6759

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY Somerset XXXXXXXXXXXXXXXXXXXX Pennsylvania			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 24 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS St. 1 Hyndman, Pa. XXX LANE AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First MARY Middle ALICE Last LEWIS		4. DATE OF DEATH Month JULY Day 31 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1906	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) MARYLAND, Carlos			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES HITCHINS				14. MOTHER'S MAIDEN NAME CATHERINE SHELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. None		17. INFORMANT St. 1 Address Edward Lewis, Hyndman, Pennsylvania			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 422.1 DUE TO Acute Myo. Cpx. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Virus infection							
INTERVAL BETWEEN ONSET AND DEATH 40 hrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from 5/10/56 19 to 7/31/56 19 that I last saw the deceased alive on 7/31/56 19 and that death occurred at 1:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) Cumberland, Md.		DATE SIGNED 8/1/56			
PHYSICIAN'S NAME (Type) Dr. Williams, M.D., Medical Building, Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/56		22c. NAME OF CEMETERY OR CREMATORY Rockhart Cemetery			
22d. LOCATION (City, town, or county)		22e. (State)		22f. (State)			
22g. (State)		22h. (State)		22i. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lafer, Cumberland, Maryland		ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR Aug. 2, 1956			
24b. REGISTRAR'S SIGNATURE Walter R. Brant, M.D.		24c. (State)		24d. (State)			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06755

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>6891 Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>6 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>211 Narrows Park</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Lewis</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weston</u> d. STREET ADDRESS <u>277 Cottage Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Alice Johnson Lilya</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 22-1873</u> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1956</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>Sweden</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Johnson</u> 14. MOTHER'S MAIDEN NAME <u>Louise- (Unknown)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Narrows Park (daughter) Annie Wiley, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs 2 mos ?</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u> EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 5-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7/7/56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Weston, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		23a. REG'D BY REGISTRAR <u>July 6, 1956</u> 23b. REGISTRAR'S SIGNATURE <u>W. L. Frantz, M.D.</u>	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please call the Registrar. If the certificate is not executed within 48 hours after death, it is void. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for 10 days. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal. VS. A15ME(S) SM 9/55

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RECEIVED

1. PLACE OF DEATH
a. COUNTY

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. # 1 Frostburg</u>		
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Violet</u> Middle <u>C.</u> Last <u>Loar</u>			4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 8, 1877</u>		9. AGE (In years last birthday) <u>78</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Martin</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Margaret Jackson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Patient's Chart</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery</u> DUE TO (c) <u>Uremia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Years 1</u> <u>(?) 1-2 months</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 8, 1956</u> to <u>July 19, 1956</u> , that I last saw the deceased alive on <u>July 10, 1956</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>B. M. Schindler</u> M.D.			ADDRESS (Street, city or town, state) DATE SIGNED <u>41 Greenbelt</u> <u>July 19, 1956</u>		
PHYSICIAN'S NAME (Type) <u>Blane M. Schindler, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/12/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>			24a. REC'D BY REGISTRAR <u>July 12, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 10 1956
BIRMINGHAM A. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06757

6788

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. LENGTH OF STAY IN 1b <u>38 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>
d. NAME OF HOSPITAL (If not in hosp. tal. give street address) OR INSTITUTION <u>231 Md. Ave</u>		d. STREET ADDRESS <u>231 Md. Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Lonnie</u> First <u>Franklin</u> Middle <u>Marsh, Sr.</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 Aug. 1883</u>
9. AGE (In years) <u>72</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George H. Marsh</u>	
14. MOTHER'S MAIDEN NAME <u>Virginia Yowell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-24-1333</u>		17. INFORMANT <u>Erwin Marsh-Westernport, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Not specified as Rheumatic</u> f.d.s.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u> <u>2 Years</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 24, 1956</u> to <u>July 14, 1956</u> , that I last saw the deceased alive on <u>July 14, 1956</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul R. Wilson</u>		ADDRESS (Street, city or town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>July 16, 1956</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Boal</u>		24a. REC'D BY REGISTRAR DATE <u>7-16-56</u>	
ADDRESS <u>Westernport, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John C. Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 19 1911

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06758

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u> Md. </u> b. COUNTY <u> Allegany </u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>Rural</u> <u>Pleasant Valley Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.C.A. the Memorial Hospital</u>			d. STREET ADDRESS <u>1722 Flintstone, Md.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Randall Langer Martin</u>			4. DATE OF DEATH Month Day Year <u>July 22 1956</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7-1951</u>		9. AGE (In years last birthday) <u>5</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert J. Martin</u>			14. MOTHER'S MAIDEN NAME <u>Martha L. Langer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>(Father) Robert J. Martin, 1722 Flintstone</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, 1. Laceration 2. intra-abdominal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>large, ruptured spleen and multiple fractures of the extremities. Hit by an automobile.</u> (c) <u>of the extremities. Hit by an automobile.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>					
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Standing along side of road, hit by an auto.</u>			
20c. TIME OF INJURY Month, Day, Year <u>8 Hour 7-22 1956</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Pleasant Valley</u>		20f. (City, town) (County) (State) <u>Cumberland Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H.V. Doming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>July 23-1956</u>	
EXAMINER'S NAME (Type) <u>H.V. Doming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 25, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>July 24, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Trantz, M.D.</u>

STREET K 2

JUL 25 1956

100-100000

Within corporate limits

6762

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>845 Mt. Royal Ave.</u>				d. STREET ADDRESS <u>845 Mt. Royal Ave.,</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>HADDEN</u> Last <u>McCLOSKEY</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>19 56</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 29, 1881</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Assist. Treas.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly-Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Salineville, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Edward V. McCloskey</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>214-07-0833</u>		17. INFORMANT <u>Mrs. Mary E. McCloskey</u> Address <u>845 Mt. Royal Ave., Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Myocardial</u> <u>infarction</u> DUE TO <u>degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Damaged of age</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>6/28/56</u> 19 <u> </u> , to <u>7/1/56</u> 19 <u> </u> , that I last saw the deceased alive on <u>7/1/56</u> 19 <u> </u> , and that death occurred at <u>5:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>122 So. Centre St.,</u> DATE SIGNED <u>7/2/56</u>							
ACTUAL SIGNATURE <u>R. Williams</u> M.D.				122 So. Centre St.,			
PHYSICIAN'S NAME (Type) <u>R. Williams M. D.</u>				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Akron, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>July 3, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>			

TO THE ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

CERTIFICATE OF DEATH

6763

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany		STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary		STREET ADDRESS (If rural give location) 157 Polk Street	
3. NAME OF DECEASED (First) (Middle) (Last) Elizabeth Motty		4. DATE OF DEATH (Month) (Day) (Year) July 13, 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 2/27/1869
9. AGE last birthday 87 yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Stanton, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Holler		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no, or unk.) (If Yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Allegany County Infirmary Records			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Pulmonary Hypostasis		24 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Myocarditis		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Cerebral Arteriosclerosis		?	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6/29/1956 to 7/13/1956 , that I last saw the deceased alive on 7/13/1956 and that death occurred at 9:05 P.M. from the causes and on the date stated above.			
SIGNATURE Dr. James E. McLean		DATE SIGNED 7/14/56	
ADDRESS (Street, city, town, state) 49 Greene St., Cumberland, Md.			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 7/16/56	
NAME OF CEMETERY OR CREMATORY Hickory Cem.		LOCATION (City, town, or county) (State) Cumb. Md.	
24. REC'D BY REGISTRAR July 16, 1956		REGISTRAR'S SIGNATURE Walter L. Brant, R.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Louis S. Lee, Inc.		ADDRESS Cumb. Md.	

1. If the death occurs within 24 hours after death, the bottom copy may be retained by the hospital or attending physician.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Canada

RECEIVED

JUL 18 1900

15

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William Henry</u> Middle <u>Moyer</u> Last <u>Moyer</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1895</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Moyer</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Simons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-7305</u>	
17. INFORMANT <u>Memorial Hospital, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1, 1955</u> , to <u>July 1, 1956</u> , that I last saw the deceased alive on <u>July 1, 1956</u> , and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William P. James</u> M.D.		ADDRESS (Street, city or town, state) <u>4411 N. Centre St. Cumberland, Md.</u>	
DATE SIGNED <u>7-2-56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. W. A. James</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 4, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Peter & Paul Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Right</u>		24. REC'D BY REGISTRAR <u>July 3, 1956</u>	
ADDRESS <u>Cumberland, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>	

8 1/2 OCTOBER

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CERTIFICATE OF DEATH

Reg. Dist. No. 8

6802

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Lonaconing		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Robbins Street				STREET ADDRESS Robbins Street		(If rural give location)	
3. NAME OF DECEASED (Type or Print) EMMA M MURPHY				4. DATE OF DEATH 7/28/1956			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 3/3/1891	
9. AGE last birthday 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Barton, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Merrbaugh				14. MOTHER'S MAIDEN NAME Mary Russell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS John Murphy, Lonaconing, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (HUSBAND)			
IMMEDIATE CAUSE (A)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C)		DUE TO					
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 28, 1956</u> to <u>July 28, 1956</u> , that I last saw the deceased alive on <u>July 28, 1956</u> , and that death occurred at <u>3 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <i>Leslie R. Miller</i>		M.D.		ADDRESS (Street, city, town, state) Lonaconing MD		DATE SIGNED July 30 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/31/1956		NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. REC'D BY REGISTRAR DATE 8/2/56		REGISTRAR'S SIGNATURE <i>Janette M Boal</i>		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		ADDRESS	

INSTRUCTIONS

1

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M.

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1950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06763

6803

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Frostburg			c. LENGTH OF STAY IN life life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Frostburg							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First Middle Last </div> <div style="display: flex; justify-content: space-around; font-size: 1.2em;"> THOMAS NEILSON </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month Day Year </div> <div style="display: flex; justify-content: space-around; font-size: 1.2em;"> July 23, 19 56 </div>									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-13-1872		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired merchant				10b. KIND OF BUSINESS OR INDUSTRY own grocery store				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Neilson						14. MOTHER'S MAIDEN NAME Margaret Shaw							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO none		17. INFORMANT Address James Neilson, Frostburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Uremia</p> <p>DUE TO</p> <p>(b) Kidney Failure</p> <p>DUE TO</p> <p>(c) General Arteriosclerosis</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>3 Days</p> <p>2 Weeks</p> <p>Years</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from April 19, 1956 to July 23, 1956 that I last saw the deceased alive on July 23, 1956 and that death occurred at Md. from the causes and on the date stated above.													
ACTUAL SIGNATURE John B. Davis, M.D.						ADDRESS (Street, city or town, state) 2 Brookside, Frostburg, Md.						DATE SIGNED 6/26/56	
PHYSICIAN'S NAME (Type) John B. Davis, MD													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-26-1956		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park				22d. LOCATION (City, town, or county) (State) Frostburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,						ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 7-26-56		24b. REGISTRAR'S SIGNATURE Miss Nancy H. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 42 hours after death.

TEAU V. 8

1956



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

067659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Big Savage Refractory Corp., Allegany, Md.		e. STREET ADDRESS 231 Welsh Hill	
3. NAME OF DECEASED (Type or print) First Joseph Middle Elmer Last Perlew		4. DATE OF DEATH Month July Day 23 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5-1905
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 56	11. IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Allegany - Big Savage Refractory Corp.		10b. KIND OF BUSINESS OR INDUSTRY Mintstone, Md.	
11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Asberry Perlew		14. MOTHER'S MAIDEN NAME Emily Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-02-6450 (son) Robert Perlew, Frostburg, Md.	
17. INFORMANT Robert Perlew, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 423.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Denning M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Denning M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 23-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-26-56	22c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery	22d. LOCATION (City, town, or county) (State) Keyser, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR 7-26-56		24b. REGISTRAR'S SIGNATURE W. Nancy N. Rose	

BUREAU V. S.

JUL 31 1956

RECEIVED
JUL 31 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

6765

CERTIFICATE OF DEATH

06766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat				d. STREET ADDRESS Cemetery Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle - Last Rizer				4. DATE OF DEATH Month July Day 7 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1977		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None: Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henery Pape				14. MOTHER'S MAIDEN NAME Elizabeth Coppage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Nine - Cemetery Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis						INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. g. l. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1956 to July 7, 1956 , that I last saw the deceased alive on July 7, 1956 , and that death occurred at 7:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. McLean, M.D.				ADDRESS (Street, city or town, state) 14 Greene St.		DATE SIGNED 7-7-56	
22a. BURIAL, CREMATION, (Type)		22b. DATE THEREOF July 10, 1956		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Frostburg, Maryland.				24. REC'D BY REGISTRAR July 10, 1956		24b. REGISTRAR'S SIGNATURE W. R. Harty, M.D.	

U. S. A. DISTRICT

COMM. 11

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06767

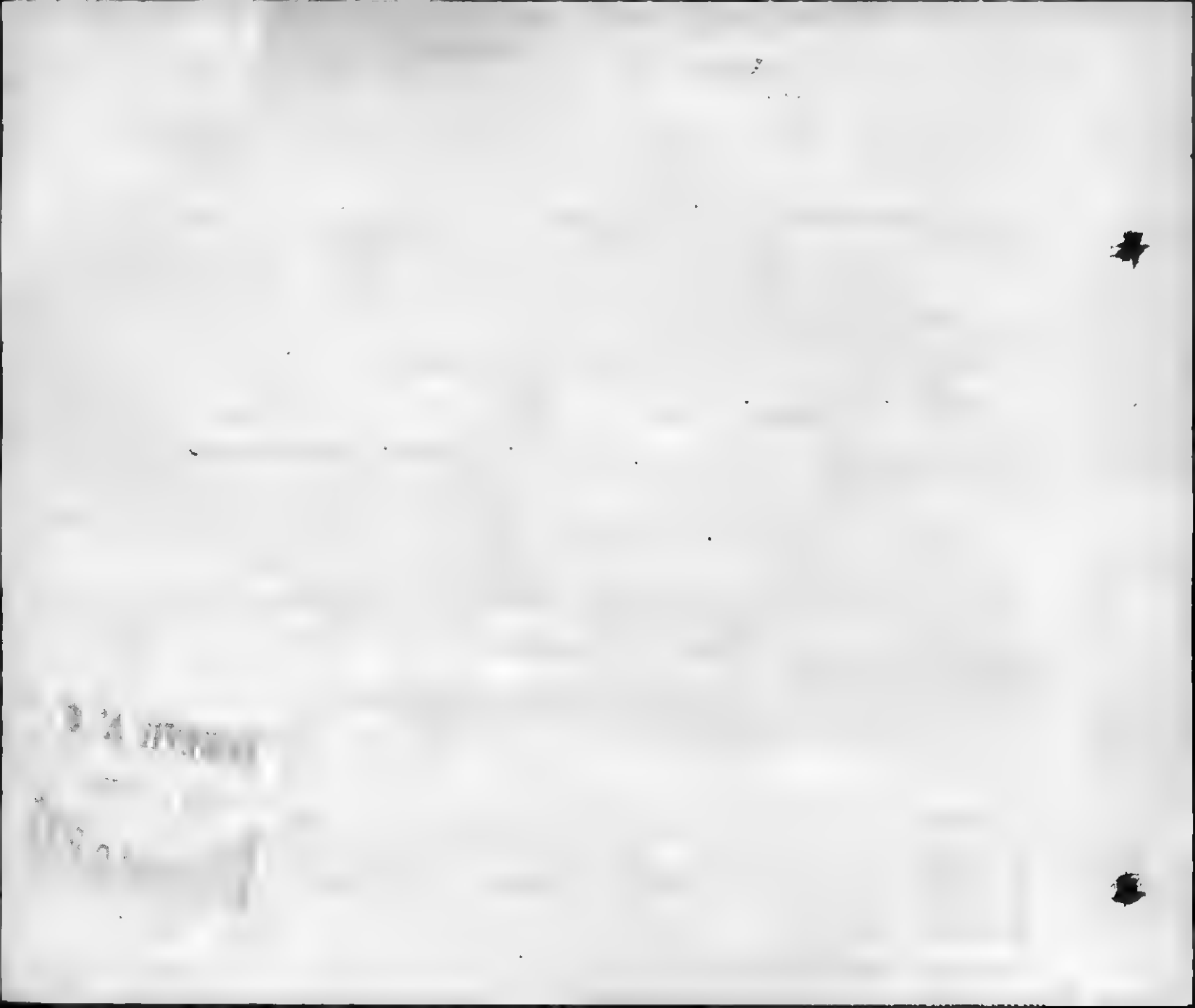
WILLIAM COMPAGNE LIMITED

6766

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cumberland Hospital</u>				d. STREET ADDRESS <u>29 Elder St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Roby</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1950</u>	9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James L. Roby, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Wanda Settle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. James L. Roby, Sr., Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure.</u> <u>7/25/56</u> DUE TO <u>Breech delivery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>22 min</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Moderate difficulty in aftercoming head.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above. <u>W. P. Hodges, M.D.</u> <u>Cumberland, Md.</u> <u>7/25/56</u>							
ACTUAL SIGNATURE _____ M.D. _____ DATE SIGNED _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Martin's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Litell, Orleans, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Carrelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>W. K. D. Reedy, Jr.</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

9

6789

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
c. LENGTH OF STAY IN 1b 7 mos.				d. STREET ADDRESS 126 Bowery St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINNIE Middle (UDY) Last RODDA		4. DATE OF DEATH Month July Day 9 Year 19 56					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Udy				14. MOTHER'S MAIDEN NAME Hannah Wardell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 319-03-9516R		17. INFORMANT Address Mrs. Mildred Myers, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency 142X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Stroke						INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 14 1955 to July 9 1956 , that I last saw the deceased alive on July 8 1956 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W O McLane		M.D.		ADDRESS (Street, city or town, state) 167 E Main		DATE SIGNED July 1956	
PHYSICIAN'S NAME (Type) W O McLane MD				Frostburg Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-1956		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 7-11-56	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 13 1905

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06769

Reg. Dist. No.

4

6767

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Porterland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at Memorial Hospital</u>				d. STREET ADDRESS <u>320 South St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Jane</u> Last <u>Rollins</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>19 56</u>			
5 SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5-1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Green Spring, L.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert H. Crowliss</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Seeders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(son) William Rollins, Ridgely, L.Va.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>several</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Dering M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Dering M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>July 23-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>July 26, 1956</u>	<u>Greenmount Cemetery</u>		<u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc., Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>July 24, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Grant, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU A. I.

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1036 A. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06770

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY 6768 Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 76 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 W. Second St.			d. STREET ADDRESS 2 W. Second St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Dessie Leora Roth			4. DATE OF DEATH Month Day Year July 12 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15-1886		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME John L. Roth			14. MOTHER'S MAIDEN NAME Susan Miller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Sidney L. Miller, Jr. Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (c), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H. V. Deming M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
NAME (Type) H. V. Deming M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER July 20-1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-21-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cen.	
				22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarnelli			ADDRESS Cumberland, Md.		
24a. REC'D BY REGISTRAR July 23, 1956			24b. REGISTRAR'S SIGNATURE W. R. Frantz M.D.		

MEDICAL CERTIFICATION

THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXERCISE CARE TO PRESERVE THE BODY. THIS CERTIFICATE IS VALID FOR 24 HOURS. IT IS THE DUTY OF THE MEDICAL EXAMINER TO SIGN THIS CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FILED IN THE MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM-3. PAGE 5 MAY BE RETAINED FOR FILES. TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. FILE PAGES 1 AND 2 WITH THE REGISTRY PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED

JUL 24 1955

RECEIVED

DR. W.F.WMS. 6769

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS R.F.D.#1, Eckhart	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle W. Last SCHAUB		4. DATE OF DEATH Month JULY Day 9 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1903
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Kelly Springfield Tire Company		10b. KIND OF BUSINESS OR INDUSTRY FROSTBURG, MD.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS SCHAUB		14. MOTHER'S MAIDEN NAME FANNIE DUNN, Euphem	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-07-9086	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Polyneuropathic Kidneys			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-15, 1955 to 7-9, 1956 , that I last saw the deceased alive on 7-9-56 , and that death occurred at 10:15 AM the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 7-9-56			
ACTUAL SIGNATURE Wm. F. Williams, M.D.			
PHYSICIAN'S NAME (Type) Wm. F. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 12, 1956	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. L. Russell		24a. REC'D BY REGISTRAR July 11, 1956	24b. REGISTRAR'S SIGNATURE Winters L. Frantz, M.D.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06772

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Little Orleans</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 Mile Creek, Adick Hollow</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Little Orleans</u> d. STREET ADDRESS <u>R.F.D. Flintstone, Md.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Clyde</u> Last <u>Shaver</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7-1940</u>
9. AGE (In years last birthday) <u>16 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Diana, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Douglas Shaver</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Star Rottew Wade Wallizer, R.F.D. Flintstone, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to drowning</u> DUE TO (b) <u>747.6</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Bathing, slipped in a deep hole, brown, unable to swim.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> <u>a.m.</u> <u>7-1</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hospital, etc.) <u>15 Mile Creek</u>		20f. COUNTY (County) <u>Allegany Md.</u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H.V. Doming M.D.</u>		DATE SIGNED <u>July 2-1956</u>	
EXAMINER'S NAME (Type) <u>H.V. Doming M.D.</u>		DEPUTY MEDICAL EXAMINER <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lafayette Memorial Park</u>		22d. LOCATION (City, town, or county) <u>Brier Hill, Pennsylvania.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stirpin Funeral Service, Rownsville, Pa.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>Thina L. Bender</u>		DATE <u>July 5, 1956</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

W. A. R. 1956

6 1956

W. A. R. 1956

Item 18 Film G200 7-13-56 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 39 OFFUTT STREET			
3. NAME OF DECEASED (Type or print) First LULU Middle VIRGINIA Last SILVIOUS				4. DATE OF DEATH Month JULY Day 2 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 22 1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) THREE CHURCHES, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT ISER				14. MOTHER'S MAIDEN NAME AMANDA ELIFRITZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Naomi Rankin Address Offutt Street Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/25 19 56 , to 7/2 19 56 , that I last saw the deceased alive on 7/2 19 56 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley M.D.				ADDRESS (Street, city or town, state) 456 N. Centre St. Cumberland, Md.			
DATE SIGNED 7/3/56							
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 7/4/56		22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery		22d. LOCATION (City, town, or county) (State) ineral County, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Jafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR July 3, 1956			
				24b. REGISTRAR'S SIGNATURE W.L. Frantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1966

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6771

CERTIFICATE OF DEATH

06774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.				c. LENGTH OF STAY IN 1b 20 days.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. STREET ADDRESS W. 1st St.			
3. NAME OF DECEASED (Type or print) First Lena Middle F Last Singer				4. DATE OF DEATH Month July Day 19 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours M.n.	IF UNDER 24 HRS Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at Home				10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Keyser				14. MOTHER'S MAIDEN NAME Sarah Virginia Huffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Patient's Chart.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bladder Cancer (Roll Back) DUE TO Bladder Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with metastases to liver & ovary DUE TO Bladder Cancer (c) Bladder Cancer						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from June 30, 1956 to July 19, 1956 , that I last saw the deceased alive on July 19, 1956 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 4/1							
ACTUAL SIGNATURE B. M. Schindler		M.D. 4/1					
PHYSICIAN'S NAME (Type) B. M. Schindler, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/21/56	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE n. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 20, 1956	24b. REGISTRAR'S SIGNATURE W. K. Williams, M.D.		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6772

CERTIFICATE OF DEATH

06775

Reg. Dist. No. 4

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 25 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL Hospital		d. STREET ADDRESS ALLEGANY INN, BALTIMORE AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First CARL Middle F. Last SLEMMER		4. DATE OF DEATH Month JULY Day 26 Year 19 56	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 22 1906
9 AGE (In years last birthday) 49 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEMIST		10b. KIND OF BUSINESS OR INDUSTRY RUBBER INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SLEMMER		14. MOTHER'S MAIDEN NAME ANNA HETZEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO 214-07-0456	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis & Uremia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Liver & Ascaris		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/15/56 , 19____, to 7/26/56 , 19____, that I last saw the deceased alive on 7/26/56 , 19____, and that death occurred at 6:58 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard J. Williams M.D.		DATE SIGNED 7/27/56	
PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28 1956	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Frantz		ADDRESS Cumberland, Md.	
24. REC'D BY REGISTRAR July 28, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...
S. A. PETERSON

COPIES TO THE

LIBRARY OF THE
U. S. DEPARTMENT OF AGRICULTURE

6773

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) b. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 ARCH STREET		d. STREET ADDRESS 27 ARCH ST.	
3 NAME OF DECEASED (Type or print) JAN JAMES L. SMITH		4. DATE OF DEATH 7-28-56	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11, 1888 - 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	
13. FATHER'S NAME CLARK SMITH		14. MOTHER'S MAIDEN NAME ELLEN HARRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 705-09-3645	
17. INFORMANT GLADUS AMITH		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure DUE TO (b) Arteriosclerotic Cardio-vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5-1-5	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not-white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1956 to July 28, 1956, that I last saw the deceased alive on July 19, 1956, and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE: Arnold G. Weissman M.D.		ADDRESS (Street, city or town, state) 57 GREENE ST CUMBERLAND, MD.	
PHYSICIAN'S NAME (Type) SAVILLE G. WEISSMAN		DATE SIGNED 7/28/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-1-56	
22c. NAME OF CEMETERY OR CREMATORY GOSHEN CEM.		22d. LOCATION (City, town, or county) (State) RICHMOND, IND.	
23. FUNERAL DIRECTOR'S SIGNATURE James J. Scarpelli		ADDRESS CUMBERLAND, MD.	
24. REC'D BY REGISTRAR July 30, 1956		24. REGISTRAR'S SIGNATURE W. K. Franz M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 11 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>U. Va.</u> b. COUNTY <u>Lincoln</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wiley Ford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cumberland Memorial Hospital</u>		d. STREET ADDRESS <u>Wiley Ford</u>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Daniel</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unemployment</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Andrew Henry Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Glos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-05-1127</u>	
17. INFORMANT <u>Bert A. Snyder, father</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Coronary sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>0 yrs.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 23-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>July 25, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul Cemetery</u>	22d. LOCATION (City, town, or county) _____ (State) _____ <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>July 24, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. R. Hantz, M.D.</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU A. B.

JUL 25 1956

RECEIVED
JUL 25 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
6775										
CERTIFICATE OF DEATH										
Reg. Dist. No. 06778 4										
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BREEZEWOOD					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARIAN Middle W. Last SNYDER					4. DATE OF DEATH Month JULY Day 16 Year 19 56					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 4, 1892		9. AGE (In years last birthday) 64 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) PENNA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK WOY					14. MOTHER'S MAIDEN NAME MARY ZINN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Breast</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 10 years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9 July, 1956</u> , to <u>16 July, 1956</u> , that I last saw the deceased alive on <u>16 July, 1956</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>W. H. Van Ormer</u> M.D.					ADDRESS (Street, city or town, state) <u>Cumberland, Maryland</u> DATE SIGNED <u>16 July 56</u>					
PHYSICIAN'S NAME (Type) <u>W. H. VAN ORMER</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>July 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Somerset, Somerset Co. Penna.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter S. Hoffman</u>					ADDRESS <u>138 C. Meigs St. Somerset, Pa.</u>		24a. REC'D BY REGISTRAR <u>W. R. Troutman, M.D.</u>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. P.

1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

6790

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 3 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 41 Maple Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES		First ADAMSON		Last STEWART	
4. DATE OF DEATH July		Month 20		Year 19 56	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-11-1880		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Substation Operator		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison		11. BIRTHPLACE (State or foreign country) Midlothian, Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John M. Stewart		14. MOTHER'S MAIDEN NAME Agnes Williamson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 214-10-471		17. INFORMANT 41 Maple Street, Ralph Stewart, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Caecum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 mo DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg		20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from Feb 1 , 19 56 , to July 20 , 19 56 , that I last saw the deceased alive on July 19 , 19 56 , and that death occurred at 9:25 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. C. Mc Lane		M.D. 167 E Main		DATE SIGNED July 21/56	
PHYSICIAN'S NAME (Type) W. C. Mc Lane M.D.		ADDRESS (Street, city or town, state) Frostburg Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-56		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg	
22d. LOCATION (City, town, or county) Md.		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Burke H. Houten		23a. REC'D BY REGISTRAR 1-23-56		23b. REGISTRAR'S SIGNATURE Mr. B. O. Price	

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 25 1956
BUREAU V. S.

DR. WEISMAN

6776

CERTIFICATE OF DEATH

06780

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN lb 95 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 523 WASHINGTON ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EMMA Middle C Last STINGLEY				4. DATE OF DEATH Month JULY Day 13 Year 19 56			
5 SEX FEMALE		6 COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 24, 1876	
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) MD.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME THOMAS F. MYERS				14. MOTHER'S MAIDEN NAME EMILY SUTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. None.			
17. INFORMANT MEMORIAL HOSPITAL - WARWICK & MEMORIAL AVES.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CIRCUMCA OF HEPATIC FLEXURE OF COLON WITH METASTASES TO LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AND ANEMIA DUE TO ABOVE (c) AND HEERT FAILURE DUE TO ANEMIA							
INTERVAL BETWEEN ONSET AND DEATH 12 mos 3 mos 3 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 9, 1956 , to July 13, 1956 , that I last saw the deceased alive on July 13, 1956 , and that death occurred at 7:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. G. WEISMAN				ADDRESS (Street, city or town, state) 596 REENE ST CUMBERLAND MD			
DATE SIGNED 7/13/56							
PHYSICIAN'S NAME (Type) S. G. WEISMAN, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 7/16/56			
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.				22d. LOCATION (City, town, or county) (State) Cumberland Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc				ADDRESS Cum. Md			
24b. REC'D BY REGISTRAR W. R. Frantz, M.D.				DATE July 16, 1956			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certifi cate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 18 1956
BUREAU K. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6791 CERTIFICATE OF DEATH

06781

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b Westernport d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rooken Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution, give address before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 215 Virginia Ave. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle Andrew Last Thomas		4. DATE OF DEATH Month July Day 28 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29 1887
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Andrew Thomas	
14. MOTHER'S MAIDEN NAME M. Alice Wymore		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT James Thomas Address Cumberland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 333X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ DUE TO lying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from July 23, 1956 to July 28, 1956 , that I last saw the deceased alive on July 28, 1956 , and that death occurred at 10 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Wolverton Jr. M.D.		ADDRESS (Street, city or town, and state) Pachmont W. Va. DATE SIGNED 7-30-56	
PHYSICIAN'S NAME (Type) James H. Wolverton Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 30, 1956	22c. NAME OF CEMETERY OR CREMATORY Levels W. Va.	22d. LOCATION (City, town, or county) (State) Levels W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE James H. Carpell ADDRESS Cumberland W. Va.		24a. REC'D BY REGISTRAR DATE 1-30-56	24b. REGISTRAR'S SIGNATURE Don C. Kelly

BUREAU VI

1956

ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06782

Reg. Dist. No. 4

6777

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>				d. STREET ADDRESS <u>405 Indiana St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2-1935</u>	9. AGE (In years last birthday) <u>20</u> yrs	IF UNDER 1 YEAR Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>	IF UNDER 24 HRS Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police - car inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.O. D.V.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Manuel Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Ella Frost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Sacred Heart Hospital records.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrathoracic hemorrhage due to a cracked chest.</u> 702.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>also had a rupture of the liver & spleen.</u> DUE TO (c) <u>a fall.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1.1 1/4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. EXTERNAL CAUSE WAS PRIMARY (or CONTRIBUTING) CAUSE OF DEATH. <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>fell over banister from second floor porch.</u>					
20c. TIME OF INJURY Month, Day, Year <u>July 6 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cumberland, Allegany, Md.</u> (County) <u>Allegany</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Dering M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Dering M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 7-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u>		22d. LOCATION (City, town, or county) <u>Cumberland, Maryland</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Mafer, Cumberland, Maryland</u>				24. REC'D BY REGISTRAR <u>July 9, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>H. R. Mantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see-
cution certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation,
or removal.

1

THE UNIVERSITY

OF CALIFORNIA

LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6778

CERTIFICATE OF DEATH

06783

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 15 RURAL and give nearest town) <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>506 Shriver Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>MAY</u> Last <u>Thrush</u>				4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Dyche</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Dawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>George Thrush</u>				Address <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of ascending colon</u> <u>15-1X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Pulmonary Metastases</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-17</u> , 19 <u>56</u> , to <u>7-26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-26</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>William R. James</u> M.D. <u>441 N. Center St.</u> <u>7-28-56</u> NAME (Type) <u>William R. James-M.D.</u> <u>Cumberland</u> <u>Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>				ADDRESS <u>Cumberland, Md.</u>			
24a. REC'D BY REGISTRAR <u>July 29, 1956</u>				24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>			

DEPT. OF JUSTICE

RECEIVED

SEP 10 1964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Alle any 6779 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Id. b. COUNTY Alle any	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumbrland		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumbrland	
f. STREET ADDRESS 215 Carroll St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Trimble Last Trimble		4. DATE OF DEATH Month July Day 3 Year 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23-1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 4	IF UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic cook		10b. KIND OF BUSINESS OR INDUSTRY P.J. Arendes	
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles C. Johnson		14. MOTHER'S MAIDEN NAME Phyllis Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 210-3-2200	
17. INFORMANT Sacred Heart as hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute nephritis (c) fractured fracture of right femur. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fractured fracture of right femur.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) falling from garbage can, fell on concrete porch.	
20c. TIME OF INJURY Month, Day, Year 11 - 6-23 19 56		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back porch		20f. (City or town) Cumbrland, Alle any (County) Alle any (State) Id.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Denning M.D.		DATE SIGNED July 3-1956	
EXAMINER'S NAME (Type) H.V. Denning M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 6, 1956	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Burial Park	22d. LOCATION (City, town, or county) Cumbrland, Maryland. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumbrland, Maryland.		24. REC'D BY REGISTRAR July 5, 1956 24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

6 1956

RECEIVED

6780

CERTIFICATE OF DEATH

06785/4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 8 HARRISON STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VERNA Middle TROUT Last		4. DATE OF DEATH Month JULY Day 19 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 23, 1881
9. AGE (In years lost birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) NEEDHAM, PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN SNYDER		14. MOTHER'S MAIDEN NAME JANE GORDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Helen Hayhurst, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 602x DUE TO Isaemia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Unilateral Calculus R. (c) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 12 days 2 yrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 5, 1956 to July 19, 1956 that I last saw the deceased alive on July 19, 1956 and that death occurred at 4:02 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 7/20/56	
PHYSICIAN'S NAME (Type) DR CLAY DURRETT			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 22, 1956	Millcrest Burial Park	Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR July 22, 1956	
		24b. REGISTRAR'S SIGNATURE R. K. Bantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BAU A. 2

JUL 24 1956

RECEIVED

6827

CERTIFICATE OF DEATH

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Moscow, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Moscow, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Moscow, Md.</u>		e. STREET ADDRESS <u>Moscow, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Louis</u> Last <u>Wilt</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1887</u>
9. AGE (In years lost in day) <u>68</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Label</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va. Paper Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank W. Wilt</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO -----	
17. INFORMANT <u>Louis Wilt</u>		Address <u>Winchester, Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4400</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs.</u> <u>"</u> <u>"</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July 19, 1956</u> to <u>July 30, 1956</u> , that I last saw the deceased alive on <u>July 28, 1956</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Leslie R. Miles, Jr.</u> M.D. <u>Sonscoming, Md.</u> PHYSICIAN'S NAME (Type) <u>Leslie R. Miles, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>August 2, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morrison Cem.</u>	22d. LOCATION (City, town, or county) _____ (State) _____ <u>Allegany Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Bral</u>		ADDRESS _____	24a. REC'D BY REGISTRAR DATE <u>8-5-56</u>
		24b. REGISTRAR'S SIGNATURE <u>John C. Kelly</u>	

MEDICAL CERTIFICATION

1

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled out by the funeral director, TO FILE: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 10 1944
BUREAU K. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06787

6808

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage-rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage-rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last WINEBRENNER				4. DATE OF DEATH Month July Day 7 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-31-1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner				10b. KIND OF BUSINESS OR INDUSTRY coal mines		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James H. Winebrenner				14. MOTHER'S MAIDEN NAME Susanna Logsdon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 213-01-4667A			
				17. INFORMANT Address Mrs. Grahame Bowers, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardosis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1954 , to July 7 1956 , that I last saw the deceased alive on July 6 1956 , and that death occurred at 5:4 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyndman Pa DATE SIGNED 7/8/56 ACTUAL SIGNATURE John A. Topper M.D. PHYSICIAN'S NAME (Type) John A. Topper							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-1956		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 7-10-56	
				24b. REGISTRAR'S SIGNATURE Veronica M. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6781 **CERTIFICATE OF DEATH**

06788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>9 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland rural</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>Pt. # 3 Bedford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Winfield</u>			4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>19 56</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/5/85</u>		9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Cumberland,</u>	
13. FATHER'S NAME <u>John Winfield</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Catharine Liobel</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05-4596</u>		17. INFORMANT Address <u>Chart Mary Winfield Bedford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>382x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Chronic Nephritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Nephritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/4/54</u> , 19 <u>54</u> , to <u>7/27/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/26/56</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>R. Williams</u>		ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u>		DATE SIGNED <u>7/27/56</u>	
PHYSICIAN'S NAME (Type) <u>Richard J. Williams</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters & Paul Cem</u>	
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>July 30, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Feantz, M.D.</u>			

CERTIFICATE OF DEATH

BUREAU V. 4

JUL 31 1956

RECEIVED